DOCUMENT RESUME

ED 328 855 CG 023 162

AUTHOR Saakvitne, Karen W.
TITLE Psychoanalytic Psychotherapy with Incest Survivors: Transference and Countertransference Paradigms.
PUB DATE Aug 90
NOTE 24p.; Paper presented at the Annual Convention of the American Psychological Association (98th, Boston, MA, August 10-14, 1990).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Child Abuse; Clinical Psychology; *Counselor Client Relationship; Counselor Performance; Counselor Role; *Incest; Individual Counseling; Psychotherapy; Sexual Abuse; *Therapeutic Environment
IDENTIFIERS *Countertransference; *Transference

ABSTRACT

Over the past decade, there has developed a steadily growing literature on the identification and treatment of survivors of childhood sexual abuse. Much of the literature has focused on the incidence and psychological impact of the abuse, and on techniques and stages of treatment. Less attention has been given thus far to the details and nuances of the analytic work, and especially to the complicated transference and countertransference elements of the therapeutic relationships. This paper outlines a range of possible transference and countertransference themes that may emerge in the psychoanalytic treatment of survivors of chronic incest. Areas of countertransference include: (1) response to the taboo against incest; (2) parental countertransference; (3) denial; (4) sexual and voyeuristic countertransference; and (5) gender related countertransference. This paper also discusses a few of the transference paradigms which can elicit strong countertransference reactions. These include the patient's mode of affect regulation, experience by the patient of the therapist as the incestuous "father," and the transference organized around the patient's identification with the aggressor. (LLL)

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PSYCHOANALYTIC PSYCHOTHERAPY WITH INCEST SURVIVORS

TRANSFERENCE AND COUNTERTRANSFERENCE PARADIGMS

Karen W. Saakvitne, Ph.D.

~~Austen Riggs Center~~

~~Stockbridge, MA 01262~~
Traumatic Stress Institute
22 Morgan Farms Dr
So Windsor, CT 06074

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Paper presented as part of the Symposium,
"Psychoanalytic Views of Trauma: Clinical, Theoretical, and Research Perspectives"
Chaired by Dr. Saakvitne at the 98th Annual Convention of the American Psychological Association
Boston, MA - August 1990

CG023162

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Psychoanalytic Psychotherapy with Incest Survivors:
Transference and Countertransference Paradigms

Over the past decade, there has developed a steadily growing literature on the identification and treatment of survivors of childhocd sexual abuse. Much of the literature has focused on the incidence and psychological impact of the abuse, and on techniques and stages of treatment. Less attention has been given thus far to the details and nuances of the analytic work, and especially to the complicated transference and countertransference elements of the therapeutic relationships. This paper outlines a range of expectable transference and countertransference themes that may emerge in the psychoanalytic treatment of survivors of chronic incest.

The first part of the paper summarizes briefly the literature on prevalence of and psychological sequelae to childhood sexual abuse, and the relevant literature on issues in psychoanalytic technique with trauma survivors. Second, the paper focuses on the general countertransference responses a therapist may bring to the therapeutic relationship in response to the knowledge of the abuse or incest. Incest survivors evoke particularly strong countertransference reactions, both at the outset of and throughout their psychctherapy. A therapist´s initial responses may include outrage, anger, fear, protectiveness, guilt, identification, disgust, blame, denial, retaliatory wishes, as well as other feelings particular to the individual. These responses can be both helpful and problematic to a therapy in various ways, but must be noticed and examined.

Third, the paper addresses particular transference issues and countertransference responses likely to emerge in psychoanalytic work with an incest survivor. Obviously, the early interpersonal experience of betrayal, fear, excitement, specialness, and abandonment can be expected to be reenacted in the therapeutic relationship. The details of this interpersonal reenactment can be difficult for a therapist to accept and analyse, particularly in the context of the overarching countertransference reactions discussed above. Yet, this ongoing careful attention to and analysis of the details and nuances of the therapist-patient relationship is critical to psychoanalytic treatment of survivors of interpersonal trauma, including incest and sexual abuse. Thus, it is important for clinicians to identify and discuss the complicated transference and countertransference paradigms one can anticipate and observe in such treatments. This paper is an attempt to identify and explore several of these paradigms.

Psychoanalytic Psychotherapy with Incest Survivors:

Transference and Countertransference Paradigms

As many of you know, current statistics indicate that the number of adult women with histories of childhood sexual abuse is strikingly high. Diana Russell's methodologically excellent interview study of 930 women (Russell, 1984) found that 28% had been sexually abused before age 14 and 38% of the women before 18, using a narrow definition of sexual abuse, (ie involving direct genital contact, penile or digital penetration, oral-genital contact). Almost half of that sexual abuse involved family members; 12% of her sample reported incest before age 14 and 16% reported incest before 18. Four and one-half percent of the respondents in her sample were involved in incest with a father or stepfather before age 18, ie, approximately 45 out of almost 1000 women in the non-clinical population were victims of father-daughter incest.

Because Russell's sample was carefully screened, her figures are conservative estimates of the actual incidence of sexual abuse and incest. The research sample is skewed toward a non-traumatized population; the sample did not include women in institutions such as prisons, psychiatric hospitals, or shelters for battered or homeless women. It did not include women who were actively drinking, drug taking, or suicidal, or who lacked stable social supports nor, obviously, women who were dead by suicide or homicide. Thus, many and the most severely traumatized women were not well represented. Russell's figures then represent a conservative and low estimate of sexual abuse incidence in a non-clinical population.

In fact, in clinical populations the ratios of women with histories of sexual abuse are much higher. Judy Herman and her colleagues (cite) report

on several studies of inpatient borderline personality disordered patients which found that 68 to 86% of all inpatient BPD patients have reported histories of sexual abuse (Herman, Perry, and van der Kolk, 1989). Herman, et al found that 81% of their BPD sample gave histories of significant trauma, that is of childhood sexual abuse, physical abuse, or witnessing serious domestic violence. Furthermore, current research suggests that borderline personality disorder, multiple personality disorder, and patients with severe dissociative disorders are all likely to have histories of childhood sexual abuse.

Given the prevalence of sexual abuse and incest in the general population and the higher prevalence in a clinical population, it is probable that most clinicians will have incest survivors among their female patients. Before I go on to discuss issues in the psychoanalytic treatment of such patients, I want to acknowledge our significant debt to the clinicians and researchers who studied and wrote about sexual abuse and incest before these topics gained acceptance and popularity, including Diana Russell (1986, 1984), David Finkelhor (1979), Albert Kinsey (1953) for their demographic work, and Judith Herman (1981), Denise Gelinas (1983), Jeanne Goodwin (1982), Suzanne Sgroi (1982) and Alice Miller for contemporary clinical writing, and to Freud and Ferenczi for their initial exploration of the impact of childhood trauma on later adult psychological functioning.

To date, the clinical literature on incest focuses primarily on incidence, the psychological impact of the childhood sexual abuse, and on techniques and stages of treatment and recovery. Far less attention has been given to the details and nuances of the analytic work and especially to the complicated transference and countertransference elements in the therapeutic relationship with incest survivors. My focus today will be on the psychoanalytic work with women survivors of chronic of father-daughter incest, although I

believe the issues raised in this paper are relevant to the psychoanalytic work with survivors of childhood interpersonal trauma, that is, trauma which occurs in the context of a relationship at the hands of another. I want to add a cautionary note here: While it is helpful in a clinical paper to use clinical examples, it is important to balance the value of letting other professionals know about one's work with the importance of not replicating an exploitative or exhibitionistic relationship. It is particularly critical in psychotherapy with incest survivors to respect and protect patient's confidentiality. The clinical examples I use today are composites of a number of patients and psychotherapies and may represent a specific incident or a representative incident.

I'm going to begin by discussing several preliminary countertransference reactions a therapist brings into the relationship at the outset of a psychotherapy with an incest survivor. There are a range of intense affective reactions a therapist may feel in response to his/her knowledge of a patient's incest history - which may include horror, outrage, anxiety, protectiveness, guilt, identification, disgust, blame, denial, arousal, retaliatory wishes, powerlessness, and grief. These countertransference reactions will be modified (or intensified) by a number of factors including: <u>therapist factors</u> such as gender, years of psychotherapy experience, particular experience working with incest survivors, awareness of and knowledge about incest, personal experiences of sexual abuse, assault, or incest, training, work in a personal psychotherapy, as well as level of comfort with intensive therapy and painful affects; and <u>patient factors,</u> such as the specific circumstances of the incest - eg, duration, age at onset and discontinuation, level of brutality, the role of the other caretakers, other children involved, etc. - and the patient's current age, circumstances, symptomatology, and

presentation. These specific variables affect the development and intensity of the therapist's countertransference reactions.

Countertransference is a central, critical component in psychoanalytic psychotherapy with trauma survivors and incest survivors, in particular. I will identify some categories of overarching countertransference reactions, that is, reactions we bring to the therapeutic relationship when we know or suspect that incest is involved. One area of countertransference is a response to the taboo against incest and to the destruction of our personal and cultural parental imagos. These feelings include horror, outrage, disgust, and rage, and are often the first line of response. Incest is a profoundly disturbing event, and we are all influenced by the cultural taboo against it and concomitant cultural repression and denial of the existence of incestuous relationships. Incest stories are difficult to hear, painful to believe, and hard to absorb the way one must absorb a patient's early environment and childhood experience in order to help her reconstruct a comprehensible, affectively accurate understanding of her personal context. It is particularly critical in a psychotherapy with an incest survivor that a therapist be consistently alert to his/her reactions to the patient and her material in order to maintain a therapeutic position, to develop a working alliance, and to protect against a negative therapeutic reaction.

The reality of incest involves exploitation, tyranny, betrayal of trust, crossing generational boundaries, and the violation of deeply held cultural values of maternal and paternal caregiving and protective functions. In addition, it is difficult to imagine and visualize the details of adult-child sexual intercourse and the images of the actual bodily contact are disturbing and painful. The abusive parent exhibits at best insensitivity or oblivion to, and distortion of a child's needs and experience, and at worst shows

profoundly disturbing levels of sadism, brutality, cruelty, and dominance, but he may simultaneously, however, be the most nurturant and empathic object available to this child in the family. These interactions and contradictions fly in the face of our deeply held cultural imagos of parents as loving caretakers whom we expect to nurture, support, and protect their children.

On the one hand, countertransference reactions of outrage, anger, and horror can be useful in the work; they represent important reality testing and witnessing, that is, validating the horror of the violation and the appropriate response of a witness to horror. On the other hand, this role must be used cautiously and only in consonance with the patient's needs. A therapist's rage for a patient may far exceed the patient's subjective experience of rage, and may get in the way of her exploration of more complex, ambivalent feelings of love, loyalty, grief, self-blame, shame, and guilt. A therapist needs to attend to these countertransference feelings, and address them not only within, but also outside the therapy itself, though consultation with colleagues always, and at times through further personal psychotherapy, or through community action. The processing is necessary to allow a therapist to do psychotherapy with these patients without being overwhelmed with outrage and the wish to act on a patient's behalf, or the need to stop listening to protect her/himself from overwhelming feelings. I found there was a point in my work with several survivors when I needed to channel my outrage somewhere outside the therapy and at that time became involved in Courtwatch, a community group organized to address issues of social justice for adult rape victims and for victims of childhood sexual assault. Joining this group allowed me to channel my anger constructively and to do something to try to prevent abuse and punish offenders, while freeing me as a therapist from the pressure of these intense feelings in the psychotherapy.

A second area of countertransference is a response to the wish to repair the damage done, to re-parent, to somehow to make it up to one's patient. This is a parental countertransference and the feelings may include protectiveness, fear and anxiety for your patient, grief, retaliatory wishes, powerlessness, and love. All of these feelings may be appropriate at times and may also be in direct response to your patient's presentation and expressed needs. However, this protective parental stance is also a common countertransference wish to undo the harm, the wound, of incest. It is an attempt to repair the violence done to the internalized benevolent image of the parent. It is analogous to an adult's response to an abandoned hurt child, that is, to act in loco parentis until a parent is located. As the psychotherapy commences and moves forward, this response can be strengthened in relation to the child within the adult patient. Understanding this countertransference and using it is key.

The concept of the child within the adult can be a very useful metaphor in the psychotherapy of incest survivors in whom a needful, vulnerable child exists in an encapsulated, isolated form, unintegrated into the adult functioning self, and in fact often an object of that adult self's rejection, contempt, and punishment. This development of split internalized objects which repetitively reenact a childhood interpersonal trauma is the cornerstone of the incest survivor's psychic life and relationship to herself (as well as of her symptomatology). A therapist often feels drawn to intervene when repeatedly invited to witness this internal reenactment of abuse between the dependent child and the neglectful or punitive parent parts of the patient's self. This reenactment takes the form of the patient's neglectful, hypercritical, or abusive response to her own feelings, needs, and wishes. This aspect of split selves as internalized objects which reenact early object

relational paradigms in an intrapersonal way is a critical aspect of these psychotherapies. A central goal of psychotherapy with an incest survivor is to redefine these intrapersonal struggles as interpersonal events, in the present with the therapist and in the past with significant objects, but I will say more about that later.

This parental countertransference paradigm can be both helpful and problematic. It can be helpful for a therapist to note and/or model appropriate parenting to a patient who has lacked that in her life, in order both to provide a reality base to help her identify inappropriate parenting from her past and to note inappropriate self-parenting responses in the present. A patient's response of surprise can be a clue to this need. One patient who expressed dismay at the formality of calling me Dr. Saakvitne, rather than by my first name, was surprised and reassured by the explicit naming of the limits in the relationship, specifically the limits of her responsibility to me, ie, that she was not responsible for taking care of or meeting my needs in this relationship, but needed to be safe to express her private feelings and needs in the context of clear boundaries and roles. Patients who have internalized extraordinarily harsh, punitive parental objects, have expressed surprise at my anger and dismay at their self-destructive or dangerous behavior, or concern for their emotional well-being at times of great pain or stress. One woman noted that it was not until she was in therapy that it occurred to her that the quality of her life mattered and not simply whether she was alive or dead. It is important to note a patient's surprise when it occurs, and use it to explore the patient's underlying assumptions about parenting, self-care, and what she needs and deserves. The therapist's attitude toward the patient as a person of value, who is entitled to care, respect, and tenderness (which she does not have to earn, but deserves because of her existence) is critical

to the treatment. This woman often does not anticipate or feel she deserves reasonable care, respect, or love from others or herself because she has accepted an identity as bad and unworthy in order to make sense of her painful experience.

On the other hand, reparenting impulses on the part of the therapist can infantalize a patient, deny the adult functioning part of the patient, and undermine a patient's strengths while ignoring other important parts of her being. It can also encourage overdependence on the therapist, often replicating the dynamics of an enmeshed family by giving the message that the therapist needs the patient to be needful, helpless, in pain, and unable to leave. The message is also that the therapist cannot tolerate the strong, independent, separate, angry parts of the patient, and in particular, may be unable to hear the patient's rage, sadism, real guilt, and identification with the aggressor. This countertransference can include an idealization of the patient or a view of her as still and only a passive victim. The patient may then feel great guilt and be driven to anger, or to betray the therapist to relieve her guilt and prove that her sense of badness is warranted. This betrayal can take the form of secrets from the therapist, self-destructiveness, or sabotaging the therapy.

In addition, this countertransference, as with the first type, can also interfere with a patient's freedom to own and explore her profound ambivalence toward her parents, especially her deep love, loyalty, protectiveness, yearning, and feelings of specialness. Parental feelings on the part of the therapist may be connected to or reflect an unrealistic rescue fantasy, a magical wish to undo and erase painful experiences, rather than acknowledge, validate, and think about how to live with its reality and consequences. Incest cannot be erased, but a woman can own her experience and be less of a victim to its sequelae, when they can be acknowledged and addressed.

Another aspect of this countertransference is the therapist's conscious wish not to replicate parental failings which can lead to a Catch 22; one can feel guilty or intrusive for asking about details of the abuse or asking probing questions about a patient's body or inner life, and on the other hand one can feel like an absent, neglectful, or unseeing parent if one avoids or does not encourage exploration of these issues. This dilemma is particularly clear with self-destructive patients. For example, I have found it important in work with bulimic or self-mutilating patients early in the work to acknowledge our dilemma, noting their strong feelings about the symptom - usually feelings of shame, secrecy, protectiveness, and guilty pleasure coupled with great anxiety, concern, fear, and helplessness - and the potential for interpersonal reenactment of either being intrusive and invasive like an incestuous father, or being neglectful and oblivious like an abandoning, passive mother. Naming the transference paradigm up front can modify the toxicity of it and help prevent a negative therapeutic reaction early in the work. It also serves an educative function about the process of transference in a treatment where the nature of the transference is likely to be intense, frightening, and overpowering. I emphasize with my patients the critical importance of our being able to talk about our relationship and the details of what happens between the two of us from the onset. This direct naming of interpersonal events is usually in stark contrast to past relationships in an incestuous family which tend to remain shrouded in secrecy, pathological denial, repression, and lies.

Both these areas of countertransference stem from powerful affective response to the existence of incest, a response that starts with disbelief, horror, and outrage, then shifts to rage and moral indignation, and then to <u>grief.</u> It is this profound grief that underlies much of a therapist and patient's need to flee. Judy Herman talks about the stage in recovery, after

the facts have been recovered and acknowledged, when a patient must deal with the intense grief both for the childhood that wasn't and for the pain of living in a world where such hurtful and unfair things happen. She underscores that at this point in treatment a patient may decide she cannot go further because the pain and immensity of the grief is too much. I believe this grief, for lost childhoods and for the ugliness and cruelty of a world where such interpersonal trauma occurs, is painful and difficult for therapist to own and survive, and yet critical to acknowledge and process if one is to work with incest survivors successfully.

A third general area of countertransference responses stem from the need not to know, not to believe it, to protect oneself from the feelings evoked by the fact of incest. This denial is natural and pervasive. This denial is not limited to a segment of therapists, but is inherent in all of us in response to powerful cultural and personal taboos and instinctive withdrawal from pain. It can take a variety of forms, from not hearing clues or hints dropped, to doubting the accuracy or veracity of a patient's memories, to doubting one's own suspicions. It can be intellectualized as a theoretical debate about fact versus fantasy, internal versus external reality, or medical-legal evidence. Field (1990) persuasively argues that many negative therapeutic reactions may be in response to a therapist's denial of or inability to hear about a trauma or abuse history, or a patient's perception that the therapist is unwilling or unable to hear this material. This denial can also stem from the therapist's repressed memories of or inability to work through and acknowledge his/her own history of sexual abuse. The danger of a therapist's denial is that we reinforce the need for secrecy and the patient's belief that she and her experience is unbearable. The burden of secrecy weighs heavily on an incest survivor who has received repeated messages to keep the secret

because the truth is unspeakable, shameful, unbearable to others (often her mother), and, worst of all, probably distorted or untrue. These fears are reinforced by even subtle messages from therapists that they cannot stand or manage the material. Many experts recommend that therapists ask about sexual abuse history during a consultation if there is any reason to suspect its presence, not because the question is likely to be answered truthfully or completely (in at least 50% of the cases a patient initially denies such a history, but reveals it later in the therapy), but because it lets a patient know that the words can be spoken by the therapist and the idea tolerated. In fact, a therapist cannot be open to hearing incest material if s/he cannot acknowledge and process the inevitable countertransference reactions, and discuss these reactions with colleagues on a regular basis.

The common trauma symptom of dissociation is also related to denial. A patient's dissociation is in part a way to manage her experienced mandate not to know which requires her to split off parts of her experience and self to avoid at all costs the integration of thoughts, feelings, memories, and bodily sensations. The goal of the psychotherapy is to <u>facilitate</u> this integration, and to help make the resulting affects tolerable and comprehensible. The achievement of this goal requires the therapist be able to hear the truth as the patient experiences and recovers it, including leaving room for later modifications. Therapists also are subject to dissociation, at times to manage the intense affects aroused by these patients and their histories. I find myself using dissociative defenses to protect myself while listening to some of these stories; at times I need to distance and concentrate on remaining calm and overtly receptive, knowing I will need to process my affective reaction later, by myself and with colleagues. At such a time, I protect my patient and myself. It is problematic, however, if such defenses become mobilized

outside of a therapist's awareness, because that follow-up processing and reconnecting then cannot occur.

Another pitfall of this denial is that the rage, both for the patient's pain and for the therapist's discomfort, gets displaced onto the patient in the form of blame and censure. This can include labeling the patient hysterical or borderline or manipulative, suspecting melodrama, insincerity, or deceitfulness, or assuming the patient had responsibility, significant control and choice about her incestuous relationship, ie, she could have stopped it, why didn't she just say no, leave the room, the house, the family? These super-ego laden criticisms are particularly dangerous, because they are inevitably feelings shared by the patient based on her distorted feelings of omnipotence and denial of the trauma and the emotional vulnerability of herself as a child.

A fourth area of countertransference which therapists often find problematic is the sexual and voyeuristic countertransference, a response to one's fascination with the forbidden, and the sado-masochistic fusion of sexuality and aggression. It includes feelings of curiosity, titillation, arousal, and excitement. These feelings are often the most discomforting because they evoke much guilt as well as narcissistic injury to the therapist as they seemingly conflict with therapist's self-image, as a helpful, compassionate professional. The discomfort is also affected by the therapist's gender; men can feel guilty about their arousal and then often angry at the patient and perhaps skeptical of her story, or can see her as seductive, aggressively using her sexuality against the therapist. Women also feel guilt, then great shame and confusion, which can be projected onto the patient who is then seen as provoking or wanting the sexual abuse. Therapists may doubt their sexuality, worrying about their sadistic, masochistic, homosexual, or exploitative sexual

impulses or feelings. The obvious dangers of this countertransference is that the therapist needs to relieve his/her discomfort by pushing the feelings away, often onto the patient, or by pushing the patient away. There are also obviously dangers if a therapist does not identify these feelings as countertransference, but shows them or feels impelled to act on them in a way that violates the boundaries, safety, and ethics of the therapeutic relationship.

It is important to note, however, that these feelings, like the other types of countertransferences, have an informative and helpful function as well. Specifically, a therapist's awareness of his/her arousal and concomitant horror provides the therapist with a powerful understanding of an incest survivor's central dilemma as a child. Darlene Ehrenberg (Ehrenberg, 1987) notes that one of the prominent and painful sequelae of incest is the disruption of a patient's relation to her own desire; because of the intense ambivalence and the great guilt about her physical and emotional arousal in response to the incestuous situation, an incest survivor's relation to her experience of sexuality, and of desire more generally, is extremely conflictual. The common solution to this conflict includes chronic dissociation, anhedonia, sexual inhibition, masochistic promiscuity, and sado-masochistic sexuality. A therapist needs to be able to hear feelings that the patient herself believes are unacceptable which will be impossible if the therapist cannot tolerate and examine his/her own conflictual feelings.

Finally, there are certain countertransference reactions that are gender related, that is reactions that reflect a therapist's personal experience as a man or woman in relation to what they know about incest. I've touched on some of these already in relation to feelings of arousal. Additionally, because incest is predominantly sexual abuse of females by males, male therapists may feel guilty and ashamed by association and struggle with feelings of

culpability and defensive anger at the same time. These feelings can interfere with their openness to hear their patient's anger or fear, or it can make them overly cautious and apologetic as though they were guilty by association. The latter reaction can lead a therapist to treat transference anger and blame as fact. Women therapists who may or may not have experience of sexual assault (and current statistics suggest that it is a very small percent of women who do not have some experience with sexual assault or harassment in their life) may feel greater rage for their patient and also identify with certain aspects of the patient's experience. While this can facilitate empathy, it can also easily lead a therapist astray by making assumptions that she knows or understands more of her patient's experience than she does . A central experience in psychotherapy with an incest survivor, which I go back to again and again, is when a patient handed me a written account of a brutal assault, with the warning, "What gets to you the most is probably not what got to me the most."

Certainly these countertransference reactions I have just discussed will develop in relation and response to a <u>particular</u> patient and her transferences, and a <u>particular</u> therapist, and a <u>particular</u> patient-therapist dyad. The final part of this paper addresses particular transference issues likely to emerge in psychoanalytic work with incest survivorsand the countertransference responses to them. Obviously, an incest survivor's early interpersonal experience of betrayal, fear, excitement, violation, specialness, and abandonment can be expected to be reenacted in the therapeutic relationship. The emotional details of this reenactment can be difficult for a therapist to accept and analyze, particularly in the context of the overarching countertransference reactions discussed above. Yet the ongoing careful attention to and analysis of the details and nuances of the therapist-patient relationship

is critical to the psychoanalytic treatment of survivors of interpersonal trauma such as incest. This trauma profoundly affects an individuals sense of trust and safety in intimate, interpersonal relationships, an incest survivor will struggle with powerful, intense, and often frightening transference reactions in a psychotherapy. A critical part of the work is holding a patient through these transference storms, which requires explicit education and anticipation of some of the feelings and the ongoing naming and exploration of those transference feelings. It is impossible in the time I have here to do more than mention a few of the expectable transference reactions which can elicit strong countertransference reactions.

1. One difficult aspect of the work is these patients' modes of affect regulation. Incest involves chronic overstimulation, affective flooding, and the fusion of sexuality, aggression, nurturance, affection, control, and sadism. Many incest survivors rely on dissociative defenses to modulate their affect, including depersonalizaton, derealization, affective numbing, fragmentation, fugue states, and what has traditionally been identified as hysterical cognition: vague, global, diffuse thinking dominated by denial, repression, and flight of ideas. These mechanisms serve to protect someone from being overwhelmed with feelings and from being too vulnerable to others. These defenses also help the patient retreat and hide from the therapist as a member of a hurtful, untrustworthy world. The patients' affects alternate between extreme dissociation or constriction, and affective flooding. In discussing the biological sequelae to trauma, Bessel van der Kolk, MD (1989) describes the pattern of fluctuations between states of numbness and hyperarousal in detail. This alternation of dissociation with flooding can make a therapist feel alternately abandoned or assaulted, which may replicate the patient's childhood experience in an abusive and neglectful family. Simultaneously,

the patient's retreat to dissociation and confusion can make the therapist feel responsible or guilty for the patient's fear as though s/he had been abusive or overstimulating. One also feels abandoned and left alone to guess where and who the patient is and what she is experiencing. When a patient is flooded with rage, anxiety, or fear a therapist can feel assaulted, overwhelmed or helpless and then neglectful or ineffectual for being unable to soothe the patient. Another aspect of dissociated affect is that a therapist is often left holding it, ie, the anger, anxiety, despair, and those intense feelings are exhausting when felt for two. It is easy to feel burdened and angry at the patient's lability and her difficulty putting words to her immediate affective experience. It is crucial, therefore, to keep the affects and their mode of expression in an interpersonal context. The emotional retreat to dissociation, "fog" and confusion is an interpersonal event, a retreat from the therapist who has become an unsafe object at that time. It is critical to note the retreat or exit from the shared space of the therapy and to try to establish the context and precipitant of that departure. Incest survivors have learned not to be in the present moment when they feel threatened and it takes considerable relearning to remain with an affect and another person at the same time. I also believe the holding of unmanageable affects by the therapist is an important component of the work, and is part of a process of the patient coming to internalize a benign object to help her manage painful affects, but this process needs to be named with the patient. In the earlier stages of the work (first two years) especially, I often know what someone is feeling by what I'm feeling even in her face of my patient's stated numbness or confusion. By naming the holding process with the patient, it is not as burdensome and isolating and confusing to the therapist.

2. A second difficult transference paradigm is the experience by

the patient of the therapist as the incestuous rapist father. Particularly in cases in which the circumstances of the incest or the overall relationship with the father has been sadistic and physically and psychologically abusive, the meaning of this expectable transference to the therapist is complex. A therapist's own outrage at the father and his actions can prevent him/her from tolerating or being able to explore the patient's experience of the therapist as like her father. For women therapists, it is a difficult role to accept, that of a male rapist, especially difficult if they find themselves identifying with their patient as a victim of sexual assault. The patient may have difficulty naming this transference directly, especially her fear of the therapist's sexual arousal, but it is critical that this fear be in the work. This transference may first emerge in the form of the patient complaining about exploitative aspects of the psychotherapy, eg, how the therapist benefits from the work by, for example, learning at the expense of the patient, or the idea that the therapist does not truly care about the patient, but is simply listening to painful and humiliating material to earn a fee and will then laugh or marvel at the material with colleagues. Eventually, one must talk with the patient straightforwardly and in detail about their experience of you as being like their abuser, specifically in their fear of your sexual arousal, but as therapists we need to get over our narcissistic injury, denial, and distaste for the comparison. It can also be difficult to identify because it may be far from our conscious experience of an interaction and of our motivations. To the extent that a therapist has had entirely different interpersonal experiences and may be able to develop trust in a relationship fairly easily, it may be more difficult for him/her to recognize the experience of someone who only mistrusts and expects disappointment and exploitation.

Another component of the father transference is the patient feeling special to the therapist. Incest survivors may pull for various modifications of therapeutic boundaries and there may be times when these modifications are useful and warranted in the work. However, it is always a mistake not to talk about them explicitly and include in the discussion both the gratifications and the dangers for the patient of feeling special. The role of incestuous partner is both a favored and a disadvantaged position in a family. To feel special to a therapist is both exhilarating and validating of the patient's worth, and it instantly arouses the spectre of exploitation, rape and loss of control. One needs to discuss both the wish and the fear without shaming or humiliating the patient. To the extent that the therapist's countertransference wish to make the patient special, or the therapist's impulsive and unexamined changes of therapeutic boundaries makes the therapist unable to think about these actions and motives, the therapist's guilt and denial will be translated to the patient and set the stage for a negative therapeutic reaction.

3. The last example I'll discuss is the transference organized around the patient's identification with the aggressor - which has two important forms; one, the patient enacting assaults and seductions on the therapist as victim and two, patients reenacting the trauma on herself, that is enacting both an abuser and a victim, often through self-destructive behavior (cutting, dangerous promiscuity, taking life-threatening risks, and extraordinarily critical super-ego attacks) to which the therapist is a helpless witness. At this time, I'll focus on the latter form. These self-attacks are assaultive to the therapist, but this element is usually out of the patient's awareness for quite a while. The work of the therapy is often to redefine the intrapersonal as interpersonal, to help her see the inner identifications and internalization

of hurtful object relations which are then endlessly repeated on herself by herself. These enactments can be difficult for a therapist for several reasons; his/her perception of the patient as a victim of assault can blind him/her to the patient's assaultiveness to herself and the therapist, or concomitantly, his/her anger at the assault can obscure the therapist's recognition of the patient's attempt to master trauma and her subjective experience of helplessness and powerlessness. The shift of these enactments from unconscious to conscious and from intra- to interpersonal is gradual and requires a therapist be aware of the subtle interpersonal shifts and name the range of identifications and ambivalent feelings. This arena often includes the need to discuss the masochistic pleasure in pain and sadistic pleasure in inflicting pain as a way of understanding the patient's experience of fused sexuality, nurturance, and aggression in the incestuous family. These patients often know no other way of being held other than to be painfully held.

In summary, psychotherapy presents a dangerous and frightening interpersonal dilemma for an incest survivor. Her anguish and need bring her to seek help, but the tasks of the psychotherapy: the interpersonal intimacy, the identification and naming of affects, the integration of thoughts, memories, affects, and bodily sensations, and the clarification of historical contexts - are the very things she has struggled to defend against in order to survive. The process is fraught with danger for her and her propensity for negative transferences make flight from treatment or a negative therapeutic reaction a very real possibility. The tracking of these interpersonal aspects of the therapy are critical to preserving a safe space for a transformative psychotherapy and to avoid the omnipresent danger of a negative therapeutic reaction. The careful and ongoing examination of transference and countertransference reactions is critical to managing these difficult treatments.

This work has to happen both in the office with the patient and in consultation with colleagues. We are all susceptible to intense and complicated responses to incest and to a survivor of incest that we need to name, tolerate, and examine ourselves in order to be clear in our therapeutic work. This work takes time as the process of building trust, identifying interpersonal paradigms, and integrating fragmented aspects of the self are gradual processes. I believe psychoanalytic psychotherapy is the treatment of choice for many incest survivors, including those with histories of chronic sadistic abuse, but I believe it must include an active interpersonal orientation and a constant analysis of a therapist's countertransference and the interpersonal relationship between the therapist and patient, both transferential and real. Thank you.

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